



Executive Office of Health and Human Services

Department of Children, Youth & Families • Department of Elderly Affairs • Department of Health •
Department of Human Services • Department of Mental Health, Retardation, & Hospitals

Global Waiver – Review and Negotiations

Who approves the Global Waiver?

The team to review and approve the waiver is the Center for Medicare & Medicaid Services (CMS) working with the Office of Management and Budget (OMB).

What does the approval process involve?

The global Waiver approval process involves a series of negotiations between the State and the Review Team. As part of the review and approval process, the Review Team may request additional information from the State. This may be done in the context of meetings, formal written questions, and scheduled conference calls. Negotiations focus on the specific details of the Global Waiver and result in a set of terms and conditions.

Are any other federal agencies involved?

The Review Team may seek input from the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Administration for Children and Families, among others.

What are the Terms and Conditions that will be included in this approval process?

There are many. They include:

- List of federal rules state is seeking to waive
- Time period to be covered by the Waiver;
- Federal funding level:
 - Base year amount and annual trend rate
 - Requirement of the State to certify state match (if applicable);
- Conditions defining the nature, character, and extent of federal involvement, and the State's conditions for participation:
 - Program description (short summary of Waiver application)
 - Waiver Objectives
 - General Program Requirements (e.g. what changes to the program would require the State to specifically notify CMS)



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- Conditions under which CMS can suspend or terminate Waiver agreement
- Conditions under which the State can terminate Waiver agreement
- State assurance of adequate infrastructure to operate under the Waiver
 - CMS may require a written or on-site “readiness review”
 - CMS may specify that the State must contract for certain expertise to assist in operating under the Waiver

Note: Both of the above were conditions of the RItE Care waiver.

- State requirements to comply with the State’s Public Notification Processes (e.g. APA)
- Definition of covered benefits
- Definition of demonstration populations (or Medicaid eligibility groups)
- Cost sharing allowed
- Delivery system related conditions, such as which delivery system contracts require federal prior approval
- Monthly, quarterly and annual reporting requirements:
 - Program Operations: (e.g. outreach and enrollment, cost sharing, access and quality monitoring activities, utilization, difficulties encountered, accomplishments, etc)
 - Financial expenditure and claiming reports
 - Requirements regarding submission of raw claims and encounter data
- Specific documents to be submitted within a specified timeframe before or after approval, e.g.:
 - Quality Monitoring and Improvement Plan
 - Detailed Evaluation Plan (evaluation and outcome measures, data sources, detailed analytical plan and reports)
 - Other documents specific to the particular waiver
- Communication:
 - Assignment of a CMS Project Officer
 - Monthly calls